Medication Assisted Treatment (MAT) Standards for Scotland

Access, Choice, Support

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SCOTTISH DRUG DEATHS TASKFORCE

Public Health Scotland

Medication Assisted Treatment (MAT) Standards for Scotland

Access, Choice, Support

The term Medication Assisted Treatment (MAT) is used in this document to refer to the use of medication such as opioids, together with any psychological and social support, in the treatment and care of people who experience problems with their drug use.

Foreword from people with lived and living experience of substance use

The road to reducing drug related deaths is rocky and twisting but is one we must persevere on if we are to go any way towards making Scotland a safe and happy place to live for everybody. All lives are precious, all children should expect to be nurtured and feel safe. All parents should expect their children to live long productive lives. As members of the Scottish Drug Death Taskforce with lived experience we have a responsibility to ensure that every avenue is explored, that the range of options is wide and daring and that people have options available at the right time, whatever the circumstances.

We have all seen drug deaths continue to rise within our communities. We believe it is vital we adapt and evolve our current systems using compassion, kindness, respect and dignity. For families, with years of experience of supporting their loved ones, removing barriers and ensuring equality of access, choice and support across all treatment and care in all areas of Scotland is essential.

By using our collective past experiences of what we know isn't working we can become thought leaders and identify new methods and systems in order to better, not only support people with drug and alcohol issues and their families, but also work with communities to become more open and inclusive to supporting vulnerable people experiencing these issues.

Our priority is to place vulnerable people at the centre of our services and the importance of treating individuals with dignity and respect, being non-judgemental in all of our approaches, and the majority of the time we are successful. However, we must continue to encourage and motivate people when they are ready to access the help and support they need.

It is vital to move towards a national approach, to ensure a consistent service will be offered and available to access around Scotland. These standards have a significant part to play in helping vulnerable people affected by substance use. It is worth considering, if you or a loved one had to engage with any service in desperate need of help and support, how would you wish, indeed expect, yourself or that person to be treated?

Optimising the use of Medication Assisted Treatment (MAT) will ensure that people have immediate access to the treatment they need with a range of options and the right to make informed choices. If an individual chooses this option within a robust Recovery Oriented System of Care (ROSC) they should expect to receive good quality, person centred care, immediately (if required) with supports into other services and opportunities for challenge and growth.

We support the implementation of the MAT Standards across our nation as an integral part in challenging all services to strive for excellence and provide high quality care no matter where you are in the country. It is vital that feedback from people in services and their loved ones contributes to learning. We recognise the ongoing investment and look forwards to supporting implementation and improvement plans.

Becky Wood, **Allan Houston**, **Colin Hutcheon**

Foreword from the Drugs Deaths Taskforce

This report recognises that we have reached a moment in time, where meaningful reform can no longer simply be talked about, but must be delivered at pace. In that knowledge, we believe that these Standards represent the most significant intervention in our battle against rising drug related harms and deaths.

They have been developed by a diverse group, including those who will deliver care and those who will benefit from that care. The intense period of consultation, was strengthened by the active contributions of individuals and families with experience of problematic drug use. We would like to thank everyone who contributed, for helping to make these Standards a reality.

The Standards are challenging, ambitious and need bold leadership to implement. The MAT Programme Team will continue to work with all partners to scale up implementation across Scotland.

Leadership and participation from people with experience of problematic drug use will be central to this phase and a key way to measure success will be the experiences of people and families that use services.

Effective implementation of the Standards will help to reduce drug related harm, including premature death, but this needs to be supported by sustained funding, workforce development, system change and culture change.

Demonstrable commitment from senior leaders in NHS boards, Local Authorities and Health and Social Care Partnerships will be critical and we welcome the Scottish Government leadership in this respect.

We are excited about working with all partners in this critical journey to improve and save lives through safe, effective, accessible and person centred care.

Professor Catriona Matheson
Chair of the Drug Deaths Taskforce

Dr Duncan McCormick
Chair of the MAT Standards Subgroup

Foreword from the Chief Medical, Pharmaceutical Nursing and Social Work Officers of Scotland

Supporting individuals, families and communities to reduce drug harm and drug deaths and ensuring people receive high quality treatment and care is a key priority.

The First Minister, in a statement to Parliament in January 2021, announced a National Mission to reduce drug deaths and harms, with a Minister for Drugs Policy appointed to lead this work of national importance.

We fully support the priorities of the National Mission and recognise that problem drug use is often multi-faceted and a symptom of a more intricate set of issues. The complex problems that people and their families face, must be recognised and tackled.

The Drugs Death Taskforce has been instrumental in driving several projects to reduce drugs based harm, one of which has been the development of Medication Assisted Treatment (MAT) Standards.

The Standards focus on how treatment is offered. They will reinforce a rights-based approach by ensuring individuals have choice in their treatment and are empowered to access the right support for where they are in their recovery journey.

We very much welcome the publication of the Standards and fully endorse the Minister's expectation of ensuring the Standards are fully embedded across the country by April 2022. Local ownership to embed these standards into everyday practise is essential. Health and Social Care Partnerships, Alcohol and Drug Partnerships and Community Planning Forums will be instrumental in their delivery and drive for improvement in the quality of support and care to meet each person's individualised needs.

The publication of the Standards is an important milestone in tackling the reduction of drugs death and harm to embed standards and treatment which are inclusive for all.

Dr Gregor Smith – Chief Medical Officer

Amanda Croft – Chief Nursing Officer

Alison Strath – Interim Chief Pharmaceutical Officer

Iona Colvin – Chief Social Work Officer

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Introduction

Scotland has a high level of drug-related deaths. The annual figure for 2019 increased from the previous year by 6 % to 1,264 and this is the highest number recorded for the sixth year in a row. The Drug Deaths Taskforce was set up in September 2019 and prioritised the introduction of standards for medication assisted treatment (MAT) to help reduce deaths, and other harms, and to promote recovery. The standards provide a framework to ensure that MAT is sufficiently safe, effective, acceptable, accessible and person centered to enable people to benefit from treatment for as long as they need.

There is good evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment. Evidence also indicates that it is important to consider medication choice and that optimum dose for an individual is critical to achieving positive outcomes. Evidence shows elevated mortality risks during the first four weeks of starting treatment and the first four weeks after leaving treatment. This demonstrates that these are critical intervention points to support people in MAT and to prevent drug-related deaths. A holistic approach, designed and tailored to the health and social needs of individuals, will improve the effectiveness of interventions, help increase motivation, prevent drop-out and improve the experience of people using services.

The most recent analysis of the circumstances of people who had a drug-related death in Scotland uses data from 2015/2016 and this shows that over half (52%) of the individuals who died lived in the 20% most deprived neighbourhoods in Scotland. These deaths are symptomatic of marginalisation and inequitable social conditions. This highlights the need to prioritise people most at risk and to offer intensive treatment and support to tackle this inequality. In 2018 NHS Information Services Scotland (now Public Health Scotland) estimated that in 2012/13, only 35% of people with problematic opioid or benzodiazepine use were in a structured treatment service.

The Scottish Government's drug and alcohol treatment strategy Rights, Respect & Recovery was published in 2018 and sets out a clear policy to deliver evidence based interventions through a public health approach. In March 2021, the Minister for Drugs Policy made a commitment to the Scottish Parliament to ensure that the evidence-based MAT standards recommended by the Drug Deaths Task Force are *'fully embedded across the country by April 2022'*. At the request of Ministers, a MAT programme of work has been set out to ensure the sustained scale up of implementation.

The standards are in line with the vision for NHS Scotland that by 2025 anyone providing health and social care will take a realistic medicine approach. This approach puts people at the center of decisions made about their care and how it is delivered. Implementation of the MAT standards is a rights-based approach and follows the principles of the *Scottish Government Health & Social Care Standards*: my support, my life, dignity and respect, compassion, inclusion and support to wellbeing.

The standards are evidence based. They were developed through extensive consultation with multiagency partners that deliver care, and, with the individuals, families and communities with experience of problematic drug use. Please see the interim report published March 2021 for full details.

The aim and scope of the standards

The MAT standards define what is needed for the consistent delivery of safe and accessible drug treatment and support in Scotland.

The standards apply to all services and organisations responsible for the delivery of care in a recovery orientated system.

The purpose of the standards is to improve access and retention in MAT, enable people to make an informed choice about care, include family members or nominated persons wherever appropriate, and to strengthen accountability and leadership so that the necessary governance and resource is in place to implement them effectively.

Format of the standards

Each standard comprises

- A statement with a plain English explanation of what this means.
- A rationale explaining why the standard is important.
- A list of criteria describing what needs to be in place to implement the standard.

Terminology

Wherever possible, we have incorporated generic terminology which can be applied across all settings. The term 'person' or 'people' is used to refer to the person experiencing MAT treatment and support. We have used the term 'provider' to refer to the relevant organisation, team or practitioner that is offering components of MAT. Where necessary, we refer to specific providers such as General Practitioners (GPs). The word 'service' refers to a particular team that is delivering MAT e.g. a city centre harm reduction team or a locality team within a Local Authority area.

Summary of the standards

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma informed care.

What do the standards mean for people who use and provide services and support?

What do the standards mean for people who are using services?

- People can get a prescription or other treatment support they request on the day they present to any part of the service. People have the right to involve others, such as a family member or nominated person to support them in their journey through care. Staff will help people to do this if they choose this form of support.
- People are informed of independent advocacy services that are available and feel able to use them to discuss the issues that matter to them.
- People are aware that treatment is not conditional on abstinence from substances or uptake of other interventions.
- People who have stopped accessing MAT or who have undergone detox are supported to easily come back into services for the care they need.
- If people miss appointments, services do not discharge them and actively get in touch to find out what people need to continue in treatment.
- People are made aware that abstinence is offered as a choice along with other treatment options.
- People will be given information and advice on recovery opportunities within their community.
- People can expect support from community pharmacists, dentists and GPs as part of their care plan, including being able to ask to move their drug treatment to their GP when appropriate.
- People are clear about what choices are available to them throughout their journey through services and are aware of their right to make their own decisions about their care plan.
- People feel listened to and involved in all decisions. They understand the different medication options available, including appropriate dose options.
- People feel able to talk about and review the choices they have made with their worker at any time. They have support if they choose from advocacy or a family member or nominated person and are encouraged to do so.
- People feel able to provide feedback, including complaints, to the service on the way they have been treated, through formal or informal channels.
- People can expect a service that is welcoming and treats them with dignity and respect, working with them to improve their health and wellbeing.
- People can get treatment and care for as long as they want to.
- People can expect that different organisations will work together to meet their needs and that information about them will be shared and stored appropriately.
- People feel involved in the design, delivery and evaluation of MAT services.

What do the standards mean for families or nominated persons?

- The service will ensure people are aware of their right to have someone, such as a family member or nominated person, to support them while they are in MAT and staff will actively assist and support people who choose this option.
- Family members or nominated persons are welcomed at visits and treated with dignity and respect. Their own experiences and points of view are acknowledged and valued when people request that they attend.
- Family members or nominated persons feel involved in choices about care plans and are encouraged to support the person in following their treatment plan.
- Family member or nominated persons are confident that if they contact a service with immediate concerns for the safety of their loved ones, of themselves, or of those around them, including children, they will receive appropriate and timely support.
- There are clear pathways that enable family members or nominated persons to use independent advocacy to raise concerns if, for example, they feel they have not been fully informed in decisions about the persons care.
- Family members or nominated persons have a named worker as a main point of contact with services and are confident that services are working together and sharing information appropriately.
- Family members or nominated persons feel involved in the design, delivery and evaluation of MAT services.
- Family members or nominated persons feel able to provide feedback, including complaints, to the service on care planning and treatment, through informal or formal channels.

What do the standards mean for staff across all services?

- Staff can feel confident and supported to discuss and offer all treatment and care options for MAT on the first day a person presents. Where the staff member is not trained to do this they should be able to use a clear pathway to refer a person on the same day to colleagues who can.
- Staff can feel confident that there are governance structures and guidance in place to enable prescribing as part of MAT, from the first day a person presents to the service.
- Staff members who are prescribing medication as part of MAT, receive regular supervision and training to remain updated on prescribing guidelines and are confident their competencies and development needs are addressed through training and support.
- Staff are clear on their responsibility to provide accessible, accurate information on medication choice and dose, conduct care plan reviews and proactively promote independent advocacy.
- Staff are clear on their responsibility to proactively identify risk and initiate appropriate action in individuals, especially those who have recently left or stopped attending the service or who are at risk of overdose due to reduced tolerance.
- Staff have clear guidance on multi-agency and multi-professional working, including clear pathways of referral and communication between partners such as community pharmacy, GPs, third sector agencies and social care.
- Staff feel confident that mechanisms are in place to maximise their wellbeing to reduce the risk of secondary traumatisation, burnout and compassion fatigue.
- Staff actively (routinely and repeatedly) encourage and help people using services to consider nominating a named person or family member to support their treatment and wider recovery.
- Staff should be aware of the needs of peoples family or others they live with and, if needed seek support for them.

Leadership and governance

Effective leadership and governance are critical to ensuring safe, person-centred and equitable services. Individuals accessing drug treatment and support should have confidence that the care they receive is of the highest quality. The table below outlines requirements for governance and leadership to implement the standards.

What do the standards mean for organisations?

- Organisations have governance, policies, resources and staff in place to establish the roles, responsibilities and lines of accountability required to deliver the standards safely. Arrangements should ensure that people accessing services benefit from partnership working at local, regional and national level.
- Multi-agency partnerships support effective information sharing in line with Caldicott principles. In particular the duty to share information can be as important as the duty to protect confidentiality.
- Clinical governance groups and multiagency partnerships support effective planning and continuous quality improvement through collation, analysis and review of data. This should include local and national epidemiological and improvement data.
- Organisations demonstrate a commitment to effective planning and continuous quality assurance through:
  - effective data collection and analysis including data on quality improvement and inequalities;
  - local and national benchmarking against agreed outcomes and standards;
  - clear alignment of strategic policy objectives and support for implementation.
- Below is a list (not exhaustive) of key policies and processes that should be in place for **all** the MAT standards of care:
  - co-ordinated, person centred pathways of care with input from third sector, health and social care partnerships (HSCP), those with living/lived experience and family members;
  - information sharing agreements that enable multiagency partnerships to deliver timely, high-quality and equitable care. These should allow for shared record keeping between the multiagency team providing care including social care, housing, community pharmacy, GPs, Police Scotland, Scottish Ambulance Service (SAS), primary and secondary care and third sector providers;
  - systems that record feedback from the person and family member or nominated person and inform quality improvement work;
  - mechanisms that enable people with lived and living experience of drug use and treatment, family members or nominated persons and staff to provide feedback, including complaints, to the service on care planning and treatment. And that can demonstrate where this feedback has resulted in change;
  - policies and procedures that demonstrate a commitment to family inclusive practice, and ensure that staff are supported to encourage and help people using services to consider nominating a family member or nominated person to support their recovery;
  - policies and procedures to ensure people are informed of independent advocacy services that empower them to access their rights and enable informed decision making;
  - systems and resource to provide evidence to demonstrate success in implementation of the standards.

The criteria set out against each standard provide further specific organisational requirements.

Evidence that standards have been successfully implemented

Meeting the standards depends on a culture of improvement and raising expectations, as much as establishing the right procedures and protocols. Process, experiential and numerical measures are all necessary to get an idea of progress and success. No single piece of evidence is sufficient on its own.

The measures

- are a guide for service improvement
- should be overseen by the local quality improvement teams
- are NOT intended for local or national performance management

The aims are to

- assess progress towards implementation
- promote quality improvement - locally and nationally
- inform the development of national indicators and quality assurance

Three types of measures are presented

1. Process. The criteria defined against each standard include the governance, guidance, pathways and standard operating procedures necessary to meet the standard safely and efficiently. Documentation is required as evidence that these are in place.

2. Experiential. The qualitative measures are designed to explore the experiences of people who use services, their family members or nominated persons and people who provide services. The aim is to measure how well the standards are being met on the ground, and whether the processes in place are translated into an experience that:
   - treats people with dignity and respect;
   - demonstrates that services strive to promote access to treatment and support;
   - promotes choice and offers people support to make an informed decision;
   - is person centred, trauma informed and inclusive of family member or nominated person (where the person wishes this);
   - provides appropriate options for whatever problem substance use the person is seeking help for;
   - facilitates a range of harm reduction approaches;
   - helps people plan for the end of treatment.

   The qualitative measures required and a proposed methodology of how to collect the evidence is provided in Appendix 1.

   The measures and approach were developed and agreed through a series of group and individual discussions with people with lived experience, family members or nominated persons and providers of services. The questions and methods which have been developed will be piloted ‘in the field’ to ensure that the design meets the aim, and will be further refined as necessary before a final version is produced.

3. Numerical. Against each of standards 1-5, one or more high level measurements are provided, with detail on what to measure, the data required to do this and what analysis to do. Methods will vary between areas because the information systems and pathways vary. This means that numerical data may not be directly comparable. But these high level measurements can be used for tracking trends and benchmarking between services, Alcohol and Drug Partnerships (ADP) and NHS Boards to facilitate learning. Some teams may wish to do deeper analysis that suits their pathway and capacity.

   The numerical measures required against standards 1-5 are in Appendix 2.

Standard 1 Same Day Access

All people accessing services have the option to start MAT from the same day of presentation.

This means that instead of waiting for days, weeks or months to get on a medication like methadone or buprenorphine, a person with opioid dependence can have the choice to begin medication on the day they ask for help.

Rationale

The Drug Misuse and Dependence: UK Guidelines on Clinical Management (2017) (Orange Guidelines) recommend that services should avoid unnecessary steps in the assessment process, particularly to reduce the risk of harm for people who need to stabilise on opioid substitution therapy. It is possible to make a diagnosis of dependence by establishing sufficient information for a prescribing decision to be made at the first appointment (2017; p37). Clinical information needed to start MAT should be obtained without adding delay as this places the person at risk of dropping out of treatment (2017; p94). Further evidence suggests that rapid access to MAT meets the needs of highly vulnerable groups, such as people experiencing homelessness, and that it reduces heroin use, HIV and hepatitis C virus (HCV) risk, injection-related and all-cause mortality and criminal charges.

Criteria

Each NHS Board should:

1.1 have a written standard operating procedure that offers 'no barrier' access to MAT;

1.2 have prescribing clinical guidelines that enable practitioners, including non-medical prescribers, to safely initiate same day prescribing as clinically appropriate;

1.3 provide practitioners that are competent to confirm dependence and to safely initiate same day prescribing. Practitioners should be available in accessible community locations, prison and custody suites for a minimum five days a week;

1.4 have policies stating that MAT is not contingent on uptake of other interventions or abstinence from other drugs.

Each ADP, HSCP and NHS Board should:

1.5 have documented pathways that offer people a range of referral options for MAT including self-referral and drop-in services. Pathways should ensure the offer of person centred care that has been developed with the person in partnership with the multiagency team, and their family member or nominated person where applicable;

1.6 have documented evidence through care planning and scheduled reviews demonstrating that peoples' views have been sought, documented and acted on;

1.7 have a documented system in place that ensures people are informed of independent advocacy and that their family member or nominated person can be included from the start in care planning;

1.8 have a process in place to periodically audit and review their services against relevant guidance and standards, including the MAT standards;

1.9 have clear governance in place to ensure that people, including their family member or nominated persons, feel able to provide feedback, including complaints, on care planning and treatment, through informal or formal channels;

1.10 ensure that staff have regular supervision and training to remain competent to deliver MAT.

Standard 2 Choice

All people are supported to make an informed choice on what medication to use for MAT and the appropriate dose.

People will decide which medication they would like to be prescribed and the most suitable dose options after a discussion with their worker about the effects and side-effects. People will be able to change their decision as circumstances change. There should also be a discussion about dispensing arrangements and this should be reviewed regularly.

Rationale

The Orange Guidelines recommend 60-120mg of methadone or 12-16mg of sublingual buprenorphine as optimal therapeutic doses. The guidance recognises that maintenance on these doses can contribute to longer term recovery and abstinence from illicit opioids, and can maintain opioid tolerance which may in turn reduce the risk of overdose. However, more recent research suggests that prescribing needs to take account of a person's perception of dose efficacy. Trujols and colleagues (2019) have identified that a person's perception of dose adequacy is influenced not just by the pharmacological effects of MAT, but also by their satisfaction with the care they receive. In this study, especially important factors were respect for autonomy and choice, the skills, behaviours and attitudes of providers, as well as the impact of stigma. Person centred care-planning that focuses on personal goals, with services working in genuine partnership with people, will result in more effective care and a better experience for people using services.

Criteria

Each NHS Board should:

2.1 have documented guidelines to ensure that methadone and long and short-acting buprenorphine formulations are equally available in local formularies and dispensing locations;

2.2 where applicable, have a home office license to allow injectable buprenorphine to be stored on NHS premises. NHS boards that do not have a Home Office licence should have standard operating procedures for named patient prescribing;

2.3 have prescribing guidelines available for each substitute prescribing option. These guidelines should take into account peoples' treatment goals, enable people to be aware of medication and dose options, and allow them to move from one medication to another.

Each ADP and HSCP and NHS Board should:

2.4 ensure that appropriate information is provided, in a written and/or verbal format, to enable people to make an informed choice;

2.5 have a documented system in place that ensures people are informed of independent advocacy services to empower them to access their rights and enable informed decision making;

2.6 have a process in place for regular review of a person's care plan. The frequency and format of reviews should be agreed between the person and provider;

2.7 have documented guidance that ensures family members or nominated persons can be included from the start in care planning for individuals who choose this form of support;

2.8 have clear governance in place to ensure that people, including family members or nominated persons feel able to provide feedback, including complaints, on care planning and treatment, through informal or formal channels;

2.9 have a process in place to periodically audit and review their services against relevant guidance and standards, including the MAT standards.

Standard 3 Assertive Outreach and Anticipatory Care

All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.

If a person is thought to be at high risk because of their drug use, then workers from substance use services will contact the person and offer support including MAT.

Rationale

Severe drug-related health harms include premature death and significant physical or mental health conditions. The type of substance used, the route of administration (such as injection) and the health of the person all have an impact on the risk of overdose and drug-related death. The combination of heroin, or other opioids, with depressants such as alcohol or benzodiazepines, contribute to particularly increased risks. In the case of people who use opioids, disruption or discontinuity of care and treatment increases the risk of harm. In certain situations, such as following detoxification, release from custody or discharge from treatment drug-free (planned and unplanned), tolerance to opioids is greatly reduced and as a result people are at increased risk of overdosing if they resume use. The risk of experiencing drug-related health harms is compounded by the presence of social and financial risk factors. The objective of this standard is to proactively identify people who are at high risk of severe drug-related harm, and to prevent the harms by rapidly providing that individual with support for engagement or re-engagement with holistic care including MAT.

Criteria

3.1 Each service within the drug treatment system should have a documented procedure to identify and follow-up people at high risk of severe drug-related harm, including death. This includes those who may have left residential, justice and inpatient settings, as well as those who have stopped attending treatment services and people who have just experienced a near-fatal overdose. The multiagency response should:

a) include at a minimum the SAS, emergency departments, primary care, public health, community pharmacy, secondary care (acute and psychiatric inpatient services), housing providers, Police Scotland and specialist drug, alcohol and mental health services;

b) ensure that engagement with a person is timely, respectful, age-appropriate and recognises the persons needs and choices;

c) take place within 24 hours (maximum 72 hours) of notification. Contact should take place in community settings, this could include at the persons own home, to maximise accessibility and address barriers presented by stigma;

d) include a comprehensive assessment of risk based on the available information and including the person and their family member or nominated person. Care provided should be tailored to the individual, documented and actioned as appropriate. Action may include rapid initiation of MAT where appropriate.

3.2 All service providers should have clear information governance structures in place to facilitate the timely sharing of information about people at high-risk, with partners who can take responsibility for follow-up. Governance must ensure that:

a) information sharing is compliant with relevant legislation and reflects Caldicott principles;

b) where people enter the pathway as a result of opt-out consent arrangements the information sharing agreements have the necessary detail to accommodate this. Requirements include the provision of information to the person on how their personal information is being used, triage of the appropriateness of entry into the pathway and provision of a means by which a person can opt-out of the pathway.

3.3 Service providers within the local partnership should have trained practitioners that are competent to carry out effective assertive outreach work in line with the requirements set out above.

3.4 All service providers should have a documented process in place to enable staff to access appropriate and timely expertise for child protection or adult protection.

Standard 4 Harm Reduction

All people can access evidence-based harm reduction at the point of MAT delivery.

While a person is in treatment and prescribed medication, they are still able to access harm reduction services – for example, needles and syringes, BBV testing, injecting risk assessments, wound care and naloxone.

They would be able to receive these from a range of providers including their treatment service, and this would not affect their treatment or prescription.

Rationale

The Orange Guidelines recommend that regular appointments during MAT titration should provide opportunistic harm reduction assessment to maximise engagement in potentially life-saving interventions (p38). These include blood borne virus diagnosis and referral, injecting equipment provision, overdose and naloxone training, wound care and assessment of risks associated with injection and poly pharmacy. It is understood that patients may decide to continue to use illicit drugs (e.g. crack cocaine, benzodiazepines or heroin) whilst in treatment and everybody accessing a substance use service should be seen as at potentially high risk of harm from injecting or other non-prescription drug use. There are benefits of MAT (e.g. opportunities to participate in psychosocial interventions, general medical care, hepatitis B, C and HIV treatment, welfare benefits, housing and peer support) that accrue over time and which may be of greater importance to the patient than the cessation of illicit drugs.

Criteria

All service providers should:

4.1 have in place a process for assessing injecting-related risk and other associated drug related harms alongside the delivery of MAT, with staff being able to offer full harm reduction advice at every relevant opportunity, including advice on the type of drugs being used and any related topics;

4.2 have a procedure in place to offer hepatitis and HIV testing and hepatitis B and tetanus, flu and covid19 vaccination, using an opt-out approach with regular follow-up as per local protocols;

4.3 have an opt-out approach to the distribution of naloxone with all staff having a supply of naloxone for use in an emergency;

4.4 have staff members trained in assessing injection related wounds and complications. Wounds should be treated onsite wherever possible or referred to a specialist service for treatment;

4.5 have staff members trained in the provision of injecting equipment and this should be offered to all. This should not impact on treatment provision;

4. 6 have a process in place to be considerate of gender-sensitive injecting assessments or general discussions with clients;

4.7 information sharing protocols are in place to allow for shared record keeping between the multiagency team providing care including social care, housing, community pharmacy, GPs, Police Scotland, SAS, primary and secondary care and third sector providers.

Standard 5 Retention

All people receive support to remain in treatment for as long as requested.

A person is given support to stay in treatment for as long as they like and at key transition times such as leaving hospital or prison. People are not put out of treatment. There should be no unplanned discharges. When people do wish to leave treatment they can discuss this with the service, and the service will provide support to ensure people leave treatment safely.

Treatment services value the treatment they provide to all the people who are in their care. People will be supported to stay in treatment especially at times when things are difficult for them.

Rationale

Evidence shows elevated mortality risks during the first four weeks of treatment and the first four weeks after leaving treatment and that the health of individuals with opioid dependence is safeguarded while in substitution treatment for at least six months. This demonstrates that these are critical intervention points to support people in substitution treatment and prevent drug-related deaths. The Orange Guidelines recommend that appointment frequencies should reflect clinical need and the efficient use of resources (p38). What is needed is a flexible response that offers different care packages ranging from low intensity for people who do not require or want more involvement, to intensive recovery packages for those that do.

Stigma, dose reduction or punitive actions due to ongoing substance use actively discourages engagement and retention in treatment. Combined peer outreach and treatment interventions, that target out-of-treatment individuals, have been shown to support people into MAT, optimize care and prevent people dropping out.

More socially stable people using services who may not need frequent attendance can be over treated or over supervised and this can have a detrimental effect on their ability to return to or sustain a stable lifestyle. Attendance requirements must not be arbitrary and should respect peoples' personal circumstances (p38). There should be flexible arrangements for appointments, particularly for people who are homeless and with co-morbidities or social issues that affect their ability to engage or organise their time (p94). Offering people only fixed appointment times is an unjustifiable barrier to access, ties up practitioner capacity and is an unnecessary waste of resources.

Criteria

All service providers should:

5.1 have pathways in place or models of support that are flexible and offer different care packages that range from low intensity for people not requiring or wanting more involvement, to intensive recovery focused packages for others. These packages should be for as long as a person wants;

5.2 have a detailed understanding of the caseload that can identify the following:

a) people with complex needs requiring intensive specialist input, e.g. the titration/re-titration phase of treatment, ongoing high-risk poly pharmacy, multi-morbidity or polysubstance use;

b) people whose needs and risk only require 2-3 monthly MAT reviews and who may be receiving support from other agencies;

c) people who can be appropriately managed in primary care through shared care arrangements.

5.3 have pathways in place to ensure that people are supported to access appropriate primary care services including GPs, community pharmacy, opticians and dentists;

5.4 have established shared care arrangements with GPs that includes proactive and supported transfer of people stable on MAT;

5.5 ensure they are effectively utilising the workforce to improve the flow of people across multidisciplinary and cross sectoral teams. This means providers must work to the highest point of their professional capacity. For example, third sector organisations provide key-working and mental health nurses conduct MAT assessments, initiation and reviews;

5.6 have information sharing protocols in place to allow for shared record keeping between the multiagency team providing care including social care, housing, community pharmacy, GPs, Police Scotland, SAS, primary and secondary care and third sector providers;

5.7 employ a variety of strategies to manage caseloads and appointment systems e.g. including group or café style clinics, 'corporate' caseloads, a mix of drop-in and fixed appointments, after-hours provision, and pharmacy-based maintenance clinics;

5.8 have monitoring and service improvement plans in place that include feedback from people in their care, and from their family members or nominated persons, to reduce non-attendance at appointments;

5.9 have a plan, agreed with the person in advance, describing how it will respond in the event of disengagement from treatment with a focus on the value of care. It should incorporate the responses from all partners, including the persons family member or nominated person, and include the option of anticipatory care planning (Standard 3).

Standard 6 Psychological Support

The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social connections.

This standard focuses on the key role that positive relationships and social connection have to play in people's recovery. Services recognise that for many people, substances have been used as a way to cope with difficult emotions and issues from the past. Services will aim to support people to develop positive relationships and new ways of coping as these are just as important as having the right medication.

Rationale

The Lead Psychologists in Addiction Services Scotland (LPASS) Report and the Orange Guidelines indicate that to be fully effective, substance use services, including MAT, need to be psychologically informed in everything they do. Also that high quality, evidence-based *psychosocial* interventions should be routinely offered by staff with the appropriate level of training, coaching and supervision.

Scottish guidance proposes that the foundation for all service delivery within a substance use service should be psychologically informed care (Tier 1). Psychologically informed care places an understanding of people's emotional and psychological needs at the heart of service delivery, and uses psychological principles and skills such as motivational interviewing to support people on their recovery journey (see LPASS report for further information on psychologically informed skills). All staff working across MAT services have a role in delivering psychologically informed care.

Structured psychosocial interventions (Tier 2) are used to support people's recovery from substance use, or mild to moderate co-morbid mental health problems, and are delivered by practitioners trained in specific evidence-base interventions. Structured psychosocial interventions can be woven into the fabric of MAT service delivery to support people's engagement and to increase the effectiveness of the treatment people receive (See LPASS report for definitions of tier 2 interventions and recommendations for delivery).

Criteria

Each service delivering MAT should:

6.1 have an explicit service plan in place for delivering psychologically-informed care and structured psychosocial interventions. Plans will include:

a) a baseline assessment of current service delivery from which to plan and build progress, and an in-built process for service evaluation and improvement;

b) an explicit workforce development policy that ensures all staff receive appropriate training to deliver psychologically-informed care and structured psychosocial interventions;

c) policies and procedures that support the translation of skills acquired through training into practice. These include:

- access for staff to regular coaching, reflective practice, and supervision to support the delivery of psychologically-informed care and structured psychosocial interventions;
- clearly defined roles for delivering structured psychosocial interventions within staff job plans, and protected time to do this;
- caseload sizes that allow staff to routinely deliver structured psychosocial interventions;
- identification and use of supportive tools, protocols, manuals and safety and stabilisation strategies to support staff in their delivery of psychological interventions;

6.2 establish a steering group to oversee the development and implementation of the above delivery plans. Steering groups will be led by addiction psychology and membership should include people with lived experience;

6.3 ensure the service culture and environment is psychologically-informed. This includes:

a) a culture that has compassion at its centre, where staff are encouraged to talk openly about how their work is making them feel, and where supporting staff wellbeing is a clear priority;
b) a clear understanding of people's emotional and psychological needs at the heart of all MAT recovery plans;
c) physical environments that are psychologically informed;

6.4 have a process in place to document experiences of people who engage with services. This would be evidenced through care planning that demonstrates the persons views have been sought, documented and acted on;

6.5 have clear pathways in place to ensure that people can access higher intensity Tier 3 & 4 psychological therapies if and when required (See LPASS Report for definitions of tier 3 & 4 interventions and recommendations for delivery).

6.6 support the development of social networks by:

a) actively promoting and linking people to services that place an emphasis on support from mutual aid and other recovery networks. There should be a clear and realistic recovery plan that outlines the network of support available to the person, including key people in their life;

b) providing support to build social capital through the promotion of connections with people in mutual aid or other pro-recovery networks;

c) providing social bonding and social bridging interventions, specifically designed to modify a person's social networks, including work with families or named persons.

Standard 7 Primary Care

All people have the option of MAT shared with Primary Care.

People who choose to will be able to receive medication or support through primary care providers. These may include GPs and community pharmacy. Care provided would depend on the GP or community pharmacist as well as the specialist treatment service.

Rationale

The Orange Guidelines identify joint working across health and social care and between hospital, prison, primary care and community drug services as a key feature of effective treatment partnerships (p13). There is an ageing population of people who use drugs and many people have underlying conditions and so would benefit from MAT delivered in General Practice, due to the possibility of wider health problems being met. MAT offered in primary care can help to address issues around access to drug treatment services in rural areas. Community pharmacists are well placed to deliver scheduled or opportunistic care because they can have very frequent contact with people picking up prescriptions or attending for other reasons.

Criteria

7.1 Primary care and substance use service partners have in place:

a) practice models that support people on MAT to remain in primary care, including for support and relapse prevention;

b) shared care protocols between specialist services, GP and community pharmacies for people who are on MAT. Shared care may include prescribing where competent practitioners are in place;

c) clinical and governance structures that enable people working in primary care to fully support people who are on MAT and to ensure that treatment and prescribing are managed alongside care for physical, emotional, and social needs;

d) contractual arrangements for primary care provision (GP and community pharmacy) reflect the requirements of MAT standards;

e) pathways that enable the transfer of appropriate elements of care between specialist services, local mental health services, GP and community pharmacy;

f) information governance to ensure that information can be safely transferred between specialist services, GP and community pharmacy, including child and adult protection procedures;

g) effective recording and review systems for recovery care planning for all people in treatment and care for problem drug use;

h) training on problem drug use and on awareness of local drug services, including non-statutory providers and peer support services for all staff who may encounter people with problem drug use in their work;

i) a ‘primary care facilitation team’, or equivalent that is responsible for auditing, monitoring, reporting and reviewing practice in primary care settings and the interface with specialist care, and for support with workforce development.

This standard will be further developed in collaboration with partners and will inform guidance on Enhanced Services for drug treatment in general practice.

Standard 8 Advocacy and Social Support

All people have access to independent advocacy as well as support for housing, welfare and income needs.

People have the right to ask for a worker who will support them with any help they need with housing, welfare or income. This worker will support people when using services, make sure they get what best suits them and that they are treated fairly.

Rationale

The single biggest structural driver of problematic drug use is poverty and deprivation. Problematic drug use is more prevalent among people from more deprived areas and from less advantaged backgrounds.

Studies have consistently shown a high prevalence of co-morbidity of mental disorders in people experiencing problematic drug use and a clear association with experiences of homelessness and the criminal justice system. People who use drugs are more likely to face poverty and deprivation. They are also more likely to face stigma in society and from the services they use as well as self-stigma (Rights, Respect & Recovery, p13). As a result they may find it much harder to have their voice heard by others, to stay engaged with services, to exercise their rights, or to know where to turn to resolve issues. Giving this group the right of access to independent advocacy is an important tool to redress this power imbalance, challenge stigma and assist people who use drugs to have their views heard; and thus to participate more fully in processes that affect them.

The Scottish Independent Advocacy Alliance defines independent advocacy as follows: *"independent advocacy is about speaking up for, and standing alongside individuals or groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice: addressing barriers and imbalances of power, and ensuring that an individual's rights are recognised, respected and secured. Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves. Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs."*

'Independence' means that an independent advocacy organisation does not provide any other service except independent advocacy. Independence is fundamental in building trust, particularly those who may have had ambivalent relationships with other services in the past.

The 'Housing First' model provides rapid housing that is not conditional on abstinence from drug use. A systematic review and meta-analysis of randomised controlled trials of the housing first approach conducted in 2019 showed improved housing stability and health, reductions in homelessness and use of non-routine health services, and no increases in problematic drug use.

Criteria

8.1 All people should be informed of independent advocacy services should they wish support in their journey through services. This should not just be raised once at the start of someone accessing services but should be offered as an option and discussed when relevant throughout.

8.2 People should have expert advice at any point of need throughout their treatment journey with regards to:

a) benefits and welfare advice;
b) housing.

8.3 People should be confident that the advocacy services have a good understanding of problematic drug use and recognised treatments.

8.4 Staff should raise the issue of independent advocacy with all people accessing services.

8.5 Staff should have clear pathways to support people with issues relating to benefit advice and with issues relating to welfare advice.

8.6 Staff should have training to understand the role of independent rights-based advocacy and have access to rights-based and health inequalities training.

8.7 Staff and management should connect with Collective Advocacy groups to ensure that the voices of people with lived experience are embedded in service change and development.

8.8 ADPs, planners and service managers should monitor referrals to independent advocacy e.g. require staff to record whether advocacy has been discussed with someone and if not why not.

8.9 Services should have established housing, welfare and independent advocacy referral pathways for all people.

Standard 9 Mental health

All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.

People have the right to ask for support with mental health problems and to engage in mental health treatment while being prescribed medication as part of their drug treatment and care.

Rationale

The Scottish Government recommends that service integration ensures alcohol, drugs, mental health and social services work jointly and in a holistic way, and that they try to improve service arrangements for dual diagnosis. In clinical practice, integrated dual diagnosis treatment is recommended, but there is limited research evidence of definite benefit. A 2013 study of onsite and integrated psychiatric service delivery found that integrating psychiatric and substance use services in opioid agonist treatment settings might improve psychiatric outcomes but not necessarily improve drug use outcomes. A 2019 study supported the benefits of integrated psychiatric and substance use care for people with opioid use disorder, with or without a co-occurring personality disorder. From the perspective of people experiencing MAT, a systematic review has identified that integrated dual diagnosis treatment has high levels of satisfaction.

The approach to delivering this standard should be based around a 'no wrong door' approach for initial assessment, within all services where it is needed, to limit dropout between services. Sequential treatment should be avoided where possible.

Criteria

Mental health services have:

9.1 procedures in place to ensure that staff in mental health services are up to date with local substance use treatment pathways and the referral criteria for NHS primary and secondary care services, social care and third sector agencies;

9.2 mechanisms in place to enable staff in mental health services to report concerns and advocate on behalf of patients at risk of falling between services;

9.3 agreed referral pathways across the local recovery orientated systems of care to support any identified substance use;

9.4 at the point of referral a named professional as the main contact responsible for communication between services, and with the person and their family member or nominated person;

9.5 training and workforce development plans to ensure staff are trained and supported to:

a) Carry out assessment of substance use and dependence;
b) recognise acute crises such as overdose, withdrawal or physical health consequences;
c) provide accurate and evidenced based harm reduction information and support to people with non-dependent substance use;
d) provide motivational interviewing where appropriate.

9.6 protocols in place for effective communication and information sharing with substance use services;

9.7 clear governance structures in place to co-ordinate care (e.g. care programme approach) and establish effective joint working arrangements to care for those with severe mental illness and substance use.

Substance use services have:

9.8 procedures in place to ensure substance use services are up to date on knowledge of local mental health services and their referral criteria;

9.9 agreed care pathways in place to support any identified mental health care needs and clear governance structures to establish effective joint working arrangements to care for people with co-occurring mental health difficulties and substance use;

9.10 mechanisms in place to enable staff in substance use services to report concerns and advocate for patients at risk of falling between the gaps of services;

9.11 assessment protocols in substance use services that include enquiry about mental health, and use of appropriate screening tools;

9.12 appropriate protocols to treat and support mental health in house (to level of competency of agency/individual) or support local onward seamless referral;

9.13 training and workforce development plans to ensure staff are trained and supported to:

a) ensure staff have the knowledge and skills to recognise acute mental health crises: suicidality/ psychosis and respond appropriately;
b) know about availability, and make use of skilled diagnosis and treatment within substance use teams if not available through mental health assessment services;
c) make use of local protocols around severity and complexity of mental health disorder for treatment in substance use, primary care or mental health teams.

9.14 at the point of referral a named professional agreed as the main contact responsible for communication between services and with the person and their family member or nominated person;

9.15 protocols in place for effective communication and information sharing with mental health services;

9.16 clear governance structures in place to co-ordinate care (e.g. care programme approach) and establish effective joint working arrangements to care for those with severe mental illness and substance use.

Standard 10 Trauma Informed Care

All people receive trauma informed care.

The treatment service people use recognises that many people who use their service may have experienced trauma, and that this may continue to impact on them in various ways.

The services available and the people who work there, will respond in a way that supports people to access, and remain in, services for as long as they need to, in order to get the most from treatment. They will also offer people the kind of relationship that promotes recovery, does not cause further trauma or harm, and builds resilience.

Rationale

The majority of people accessing MAT services are likely to have extensive histories of complex trauma, the consequences of which may be intrinsically linked to the individual's drug use. Unaddressed trauma related issues are a significant barrier to people accessing, and benefitting, from MAT services. Providing trauma-informed services can promote recovery and improve outcomes for individuals, their families, staff and services.

Psychological trauma is everyone's business. We all have a part to play in understanding and responding to people recovering from trauma. It is the Scottish Government's ambition to have a trauma informed and trauma responsive workforce, who ensure all services are delivered in ways that prevent harm or further trauma, and promote recovery.

Trauma informed care reflects a model that is grounded in, and directed by, a complete understanding of how trauma affects service user's neurological, biological, psychological and social development.

Five key principles underlie trauma informed care: safety, trust, choice, collaboration and empowerment. Service delivery and the care provided should align with these principles, and drive change when necessary. Trauma informed care can only be delivered as part of a wider system of psychologically informed care. Local substance use psychology services can support implementation of this standard.

Criteria

10.1 MAT services should have an explicit delivery plan in place for delivering trauma informed care that takes into account the 5 key drivers for organisational change recognised by NHS Education for Scotland: engagement with people with lived experience of trauma in all aspects of service delivery, evaluation and improvement planning, developing trauma-informed leadership, growing workforce knowledge and skills, promoting workforce wellbeing, and collecting data and information to evaluate services.

Delivery plans should:

a) be informed by a baseline assessment of current trauma informed care delivery. A tool that can support this process is the Trauma-informed Care and Practice Organisational Toolkit (TICPOT);

b) consider the physical environment in which MAT is delivered;

c) include mechanisms to maximise staff wellbeing and reduce the risk of secondary traumatisation, burnout and compassion fatigue - such as policies for regular supervision;

d) include people with lived experience of trauma and their family member or nominated person in all aspects of service delivery, evaluation and improvement planning (where the person wishes this);

e) ensure that the knowledge and skills of the MAT workforce (including senior leaders) are aligned to the Transforming Psychological Trauma: Knowledge & Skills Framework;

f) ensure alignment of practice with MAT Standard 6 Psychological support and the use of validated tools for routine trauma screening;

g) ensure that service evaluation and continuous quality improvement is underpinned by the principles of trauma informed care.

10.2 A steering group should be established to oversee the development and implementation of trauma informed care across MAT services.

Further Support from National Trauma Training Programme

The Trauma Informed Practice Toolkit for Scotland is a freely available resource that can support your service to undertake this journey towards delivering trauma-informed care.

Further information and resources are also available from the National Trauma Training Programme (NTTP).

Appendix 1 Qualitative Measures of Implementation

Purpose

The qualitative measures are designed to explore the experiences of:

a) people currently using services and the wider group of people who may need services;

b) family members or nominated persons;

c) people who provide services;

The aim is to measure how well the standards are being met on the ground, and whether the process and structures put in place are translated into an experience that:

a) treats people with dignity and respect;

b) demonstrates that services strive to promote access to treatment and support;

c) promotes choice and offers people support to make an informed choice;

d) is person-centred, trauma-informed and family member or nominated person inclusive (where the person wishes this);

e) provides appropriate options for whatever problem substance use the person is seeking help for;

f) facilitates a range of harm reduction approaches;

g) helps people plan for the end of treatment.

Meeting the standards depends on a cultural of improvement and raising expectations, as much as establishing the right procedures and protocols. The intention is to use the experiential information gathered to promote continuous quality improvement and support the implementation of the standards.

Approach

The questions are inevitably slightly different for each group whose views are being sought, but are designed to mirror and explore the same themes. [sample questions to be piloted will be available as part of the suite of resources]

People who use services or are potentially in need of services

The questions are framed in such a way as to make sense for people who have very different experiences of services, from very recent to longer term, and whose problems relate to different substances. The aim is to capture the range of experiences that people have in terms of how services have - or have not – succeeded in giving them the care and support they needed, in a timely fashion.

It is anticipated that peoples' experience will change as the MAT standards are rolled out, and that the ongoing exercise of seeking their views will in itself contribute to change, in shaping peoples' understanding and expectations of what options are available to them.

People who provide services

The implementation of the MAT standards is a process and clearly some services will be able to make faster progress than others, according to factors such as location, available resources, numbers of staff, and their levels of skills and confidence.

The aim is to elicit information in a way that acknowledges these issues, so that services are helped to identify gaps and areas where support may be needed to make further progress, at the same time as highlighting examples of best practice that can be shared.

Family or nominated persons

All people accessing services should be asked if and who they would like to nominate to be alongside them (with 'family' defined in the broadest sense).

Questions are designed to explore how well family inclusive practice is integrated, and to what extent families are facilitated and supported to accompany, support and be involved with peoples care and treatment.

What will be measured

The questions do not rigidly follow the order of the MAT standards but aim to capture the key questions of choice, access and respect for the person as principles for implementation. They are designed to find out whether:

- people understand they can have access to treatment on the day of presentation and receive a prescription or appropriate support on the day of their first visit;
- people are able to access care and support whatever substances they are using or is problematic for them;
- people feel they are supported and are given enough information to make the right choice for them, are satisfied with their decision and feel able to ask for a review of their choice;
- people feel comfortable to ask for the information and support they need to keep safe and well and have access to the full range of harm reduction approaches;
- people feel confident that their information will be shared between services to help them in a crisis and feel confident their family member or nominated person will be contacted in a crisis;
- people are confident they will be supported to re-engage with services if they have dropped out;
- people feel the service is responsive to their needs and have a sense of progress;
- people feel they are treated fairly, and with compassion;
- family members or nominated persons feel they are included in discussions about peoples care and treatment;
- family members or nominated persons feel they are listened to and taken seriously if they contact a service with concerns, including about immediate risk of harm;
- service providers know about and understand the purpose of the MAT standards;
- service providers are able to offer care and treatment at first appointment, including prescription for opioid users and appropriate support for people with other types of problem substance use;
- service providers are – and feel - supported to gain the knowledge skills and confidence to implement the standards;
- service providers are able to offer the full range of harm reduction interventions (Wound care, BBV Testing/Vaccination/treatment, Safer Injecting advice, IEP, Naloxone).

Delivery

The qualitative evaluation will be carried out in local ADP (Alcohol & Drug Partnership) areas in partnership with local teams.

It is intended to pilot the measures over a 3-6 month period to test the approach and delivery method.

This is important in order to explore some key questions for the future implementation of the evaluation programme, for example:

- what capacity already exists in local areas to do this work?
- what extra support is required to build capacity and resource?
- how will this be developed into a sustainable and consistent model?
- is the current design effective in gathering the required information?

The answers to these questions will ensure that method and design are refined and adapted if necessary and will inform the development of a framework for analysis.

Appendix 2 Numerical Measures for Standards 1-5

Standard 1 All people accessing services have the option to start MAT from the same day of presentation.

What to measure?	How long does it take from first presentation to starting a prescription as part of MAT?
Required data items	For each individual person – Date and time[a] of first contact with any partner in the multi-agency partnership within an episode of care. – Date and time[a] of first prescription within an episode of care. – Age, gender, setting and service. For the given period e.g. month, quarter, year – Number of people started on MAT.
	1. Mean, median or mode length of time between first contact and first prescription[b]. 2. Range or interquartile range of length of time between first contact and first prescription[c]. 3. Proportion of people started on MAT within a given time period (e.g. month, quarter, year) who started MAT within a given time period (e.g. 1 working day, 2 working days, 3 working days, 5 working days and more than 5 working days)[d]. 4. Disaggregated into age, gender, setting and service.
What these measures demonstrate	1. Demonstrates the typical period of time taken for a people to start MAT from initial contact with any partner in the multi-agency partnership. 2. &3. Demonstrates the variation in the period of time taken for people to start MAT. 4. Demonstrates any differential access according to age, gender, setting and service. Note: Assessment of the trend in measures will help to determine the rate of change in time from first contact to starting MAT
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change
Potential data sources	– Drug and Alcohol Information System (DAISy) – Prescribing Information Systems (PIS or PRISMS) – NHS partners: local patient management systems e.g. TRAK, EMIS/VISION – Third sector: local case management records – Social care: local case management records e.g. SWIFT – Local prescribing system: e.g. Illy, Nebula.

Notes	a. Date and time will enable a more accurate calculation of the period of time taken to start MAT, but date will be sufficient. b. The mean, median and mode gives a measure of where the center of the data falls, but often give different answers. The mean is most frequently used measure of central tendency, but there are some situations where either the median or the mode are preferred. The median is the preferred measure when there are a few extreme data point (e.g. patients that have very long lenths of wait) that would have a great effect on the mean. The mode is the most common value and is useful when data are categorical measurements (e.g patients on each OST type). c. The range gives a measure of the spread or variability of the whole data set, while the interquartile range gives you the spread of the middle half of the data set. The interquartile range is the best measure for data sets with a few extreme data points (outliers) because it is based on values that come from the middle half of the data set, it's unlikely to be influenced by outliers. d. These are suggested splits, others may be more appropriate for your service depending on the range of time periods involved within your service. e. Some services may wish to do further analysis of the local pathway e.g. between (a) initial presentation to any member of the multiagency team; (b) to referral to the nursing team; (c) to consultation with the nursing team. (d) to prescription; (e) to dispensing. This may help to identify specific challenges and opportunities for improvement at different parts of the pathway.

Standard 2 All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose

What to measure?	Number of people on the different opioid substitution medications.
Required data items	For the given snapshot (e.g. end of month/quarter/year) – The number of people on the MAT caseload taking methadone, – The number of people on the MAT caseload taking oral buprenorphine, – The number of people on MAT caseload taking injectable buprenorphine, – The number of people on MAT caseload taking heroin assisted treatment, – The number of people on the MAT caseload. – Age, gender, setting and service.
Proposed measure and disaggregation	1. Percentage of people currently on the MAT caseload taking each type of opioid substitution therapy medication – Percentage of people on the MAT caseload taking methadone, – Percentage of people on the MAT caseload taking oral buprenorphine, – Percentage of people on MAT caseload taking injectable buprenorphine, – Percentage of people on MAT caseload taking heroin assisted treatment. 2. Disaggregated into age, gender, setting and service.
What this measure demonstrates	1. Demonstrates people are provided different medication options. 2. Demonstrates any differential access according to age, gender, setting and service.
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Drug and Alcohol Information System (DAISy) – Prescribing Information Systems (PIS or PRISMS) – NHS partners - local patient management systems e.g. TRAK / EMIS/ VISION – Local prescribing systems e.g. Illy / Nebula – Local manual data capture systems

Note: Some services may wish to do further analysis on the dosage offered to people. This may help to identify specific challenges and opportunities for improvement on the appropriate dose for people.

Standard 3 All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT

Measure 3.1

What to measure?	How long does it take from recognition of risk to first contact and assessment?
Required data items	For each individual person – Date and time[a] of first identified as at risk – Date and time[b] of first contact and initial assessment – Age, gender, source of risk event (e.g. SAS, Emergency Department), and service providing initial assessment For the given period (e.g. month, quarter or year) – Number of people first identified as at risk, – Number of people followed up and an initial assessment performed.
Proposed measures and disaggregation	1. Mean, median or mode length of time between first identified as at risk and initial assessment[c]. 2. Range or interquartile range of length of time between first identified as at risk and initial assessment[d]. 3. Proportion of people seen within a given time period (e.g. month, quarter, year) who received an intervention within a given time period (e.g. 24, 48, 72 and more than 72 hours)[c]. 4. Disaggregated into age, gender, source of risk event and service.
What these measures demonstrate	1. Demonstrates the typical period of time taken for a person between being first identified as at risk and receiving an Initial assessment. 2. & 3. Demonstrates the variation in the period of time taken for follow up. 3. Demonstrates any differential access according to age, gender, source of risk event and service.
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Public Health Scotland Accident & Emergency Datamart for drug overdose/intoxication Emergency Department attendances – Scottish Ambulance Service: Date and time of emergency naloxone administration – NHS partners: local patient management systems e.g. TRAK/EMIS/VISION – Third sector: local case management records – Social care: local case management records e.g. SWIFT
Notes	a. Date and time will enable a more accurate calculation of the period of time taken to start MAT, but date will be sufficient. b. The mean, median and mode gives a measure of where the center of the data falls, but often give different

	answers. The mean is most frequently used measure of central tendency, but there are some situations where either the median or the mode are preferred. The median is the preferred measure when there are a few extreme data point (e.g. patients that have very long lenths of wait) that would have a great effect on the mean. The mode is the most common value and is useful when data are categorical measurements (e.g patients on each OST type). c. The range gives a measure of the spread or variability of the whole data set, while the interquartile range gives you the spread of the middle half of the data set. The interquartile range is the best measure for data sets with a few extreme data points (outliers) because it is based on values that come from the middle half of the data set, it's unlikely to be influenced by outliers. d. These are suggested splits, others may be more appropriate for your service depending on the range of time periods involved within your service. e. Some services may wish to do further analysis of the local pathway e.g. between (a) initial presentation to any member of the multiagency team; (b) to referral to the nursing team; (c) to consultation with the nursing team. (d) to prescription; (e) to dispensing. This may help to identify specific challenges and opportunities for improvement at different parts of the pathway.

Measure 3.2

What to measure?	Who is being identified as at risk?
Required data items	For each individual person – Age – Gender – Source of risk event For the given period (e.g. month, quarter or year) – Number of people identified as at risk
Proposed measures and disaggregation	1. Proportion of people by gender, age, source of at risk event and service providing initial assessment.
What these measures demonstrate	1. Characteristics of individuals being identified as at risk. How do these compare with expected patterns amongst people at risk of harm? 2. The source of risk events in order to inform further development work and demonstrate any differential access according to age, gender, source and service.
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Drug & Alcohol Information System (DAISy)

	– Public Health Scotland Accident & Emergency Datamart for drug overdose/intoxication Emergency Department attendances – Scottish Ambulance Service: Date and time of emergency naloxone administration – NHS partners: local patient management systems e.g. TRAK/EMIS/VISION – Third sector: local case management records

Measure 3.3

What to measure?	Outcome of referral
Required data items	For each individual person identify outcome of initial intervention – Community intervention – No intervention – Follow up in service For the given period (e.g. month, quarter or year) – Number of people referred to outreach service
Proposed measures and disaggregation	1. Proportion of people by outcome. 2. Disaggregated into age, gender, referral source and service.
What these measures demonstrate	1. Demonstrates outcomes which may require further work e.g. through audit to identify improvement actions. 2. Informs further development work and demonstrates any differential improvement actions according to age, gender, source and service.
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Drug and Alcohol Information System (DAISy) – Local referral information systems – Public Health Scotland Accident & Emergency Datamart for drug overdose/intoxication Emergency Department attendances – Scottish Ambulance Service: Date and time of emergency naloxone administration – NHS partners: local patient management systems e.g. TRAK/EMIS/VISION – Third sector: local case management records

Standard 4 All people can access evidence-based harm reduction at the point of MAT delivery.

What to measure?	Number of services offering evidence-based harm reduction at point of MAT delivery.
Required data items	For each MAT service: Indication of which harm reduction interventions are offered by the service; • BBV testing and vaccination • Naloxone and overdose awareness - supply and encourage to carry on the person Wound care - early identification, treatment and advice of possible problems Assessment of injecting risk – including technique and safer injecting advice • Injecting equipment provision
Proposed measures and disaggregation	1. Proportion of MAT services offering each harm reduction intervention. – Proportion of services offering BBV testing and vaccination – Proportion of services offering naloxone and overdose awareness – Proportion of services offering wound care – Proportion of services offering assessment of injecting risk – Proportion of services offering injecting equipment provision
What these measures demonstrate	1. Demonstrates the suite of harm reduction interventions offered by MAT services. 2. Assessment of the trend in measures will help to determine the rate of change.
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Review of service procedures

Standard 5 All people will receive support to remain in treatment for as long as requested.

What to measure?	How long do people remain in MAT treatment?
Required data items	For each individual person – Date of first prescription within an episode of care. – Date of discharge. – Reason for discharge (e.g. planned or unplanned) where user has been discharged. – Age, gender, setting and service For the given snapshot (e.g. end of month, quarter or year) – Date of snapshot. – Number of people currently on MAT treatment. – Number of people discharged.
Proposed measures and disaggregation	1. Mean, median, or mode[a] length of time people are on MAT treatment. 2. Range or interquartile range[b] of length of time people are on MAT treatment. 3. Proportion of people on MAT for less than 3 months, between 3 and 6 months, and more than 6 months [c]. 4. Proportion of people discharged by reason (e.g. planned and unplanned) within a specified period(e.g. month, quarter or year). 5. Disaggregated into age, gender, setting and service.
What these measures demonstrate	1. Demonstrates the typical period of time on MAT treatment. 2. Demonstrates the variation in the period of time on MAT treatment between people in the service. 3. Demonstrates the share of people in treatment for various periods of time. 4. Demonstrates the proportion of people actively engaged or otherwise with the service. 5. Demonstrates differential retention according to age, gender, setting and service. Note: Assessment of the trend in measures will help to determine the rate of change in time from first presentation to starting MAT
Frequency	This will depend on things like the throughput of the service, the stage of the service development and the method for collecting the data. In general monthly reporting of numerical measures will enable an assessment of the trend and will help to determine the rate of change.
Potential data sources	– Drug and Alcohol Information System (DAISy) – Prescribing Information Systems (PIS or PRISMS) – NHS partners: local patient management systems e.g. TRAK,EMIS/VISION – Local prescribing system: e.g. Illy, Nebula
Notes	a. The mean, median and mode gives a measure of where the center of data falls, but often give different answers. The mean is most frequently used measure of central tendency, but there are some situations where either the median or the mode are preferred. The median is the preferred measure when there are a few extreme data point that would have a

	great effect on the mean. The mode is the most common value and is useful when data are categorical measurements (e.g patients on each OST type). b. The range gives a measure of the spread of the whole data set, while the interquartile range gives you the spread of the middle half of the data set. The interquartile range is the best measure for data sets with a few extreme data points (outliers) because it is based on values that come from the middle half of the data set, it's unlikely to be influenced by outliers. c. These are suggested splits, others may be more appropriate for your service depending on the range of time periods involved within your service.

Acknowledgments – alphabetical order

Authors – Tracey Clusker, Elinor Dickie, Dr Duncan McCormick

Dr Seonaid Anderson	NHS Grampian
Lee Barnsdale	Public Health Scotland
Gwen Bayne	NHS Lothian
Alan Blood	Information & Research Officer, NHS Lanarkshire
Jed Brady	Reach Advocacy
Caroline Bruce	NHS Education for Scotland (NES)
Dr John Budd	NHS Lothian
Emma Callinan	Public Health Scotland
Dr. Claire Campbell	Consultant Psychologist, NHS Tayside
Michael Crook	Scottish Government
Dr Greig Coull	Consultant clinical Psychologist/Head of Substance Use Psychology, Borders
Dr Fiona Cowden	NHS Tayside
Lorna Douglas	NHS Lothian
Sharon Glen	National trauma Training Programme Policy Lead, Scottish Government
Alan Houston	Person with lived experience Scottish Drug Deaths Taskforce MAT Subgroup
Sue Hudson-Craufurd	NHS Lothian
Sandra Ferguson	NHS Education for Scotland (NES)
Kim Gallacher	Scottish Government
Carole Hunter (since April 2020)	Chair, Scottish Pharmacists in Substance Misuse Scottish Drug Deaths Taskforce MAT Subgroup
Lucy Hetherington	Scottish Government
Kirsten Horsburgh	Scottish Drug Forum
Colin Hutcheon	Drug Death Taskforce Scottish Families Affected by Alcohol & Drugs
Independent Advocacy Providers Development Group (Substance Use)	
Laura James	Improvement Service
Dr Ahmed Khan	Royal College of Psychiatrists
Lived Experience Reference Group	
Lived Experience Reference Organisations	
Scott Clements	Scottish Families Affected by Alcohol & Drugs
Dave Liddell	Scottish Drugs Forum, MAT Subgroup
Dr. Peter Littlewood	Chair, Lead Psychologist in Addiction Services Scotland
Jean Logan	Scottish Pharmacists in Substance Misuse
Dr Carey Lunan	Royal College of GPs Scottish Drug Deaths Taskforce MAT Subgroup
Derek McCabe	Reach Advocacy
Karen Mailer	Public Health Scotland
Dr Rebecca Lawrence	Consultant Psychiatrist, NHS Lothian

	Royal College of Psychiatrists Addiction Faculty Chair
Joanna McLaughlin	Improvement Service
Coleen McLeod	NHS Western Isles
Prof Catriona Matheson	Chair, Scottish Drug Death Taskforce
Dr. Laura Mitchell	Consultant Clinical Psychologist, NHS Ayrshire & Arran
Justina Murray	Scottish Families Affected by Alcohol & Drugs
Sharon Mooney	Scottish Government
Scott Murphy	Advocard
Dr Alison Munro	University of Dundee
Maggie Page	Scottish Government
John Player	CAPS Advocacy
Lindsey Murphy	Public Health Scotland
Dr. Christopher Pell	Consultant Psychiatrist, NHS Tayside
Dr Saket Priyadarshi	NHS Greater Glasgow & Clyde MAT Subgroup
Simon Rayner	Aberdeen City ADP MAT Subgroup
Kyna Reeves	CAPS Advocacy
Dr Trina Ritchie	NHS Greater Glasgow & Clyde
Aidan Reid	Royal College of Psychiatrists
Carol Ross	Aberdeenshire HSCP – need to check this is correct
Lauren Ross	Scottish Government
Joe Schofield	Drug Research Network Scotland
Nicholas Smith	Scottish Government
Scottish Families Reference Group	
Dr. Tara Shivaji	Consultant in Public Health Medicine, Public Health Scotland
Austin Smith	Scottish Drugs Forum
Geraldine Smith	Scottish Government
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Dr Ewen Stewart	RCGP
Dr Joe Tay	NHS Lothian
David Taylor	ARIES, Aberdeenshire
Liz Taylor	Public Health Scotland
Dr. James Tidder	NHS Borders
Dr. Isabel Traynor	Consultant Clinical Psychologist, NHS Fife
Chris Wallace	Communications Consultant for Scottish Drug Death Taskforce
Richard Watson	Drug Death Task Force
David Williams	Edinburgh Alcohol and Drug Partnership
Liam Wells	Ayrshire Alcohol and Drug Partnership
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